Florida Statutes 641.31 – Return to Home Law

(25) If a subscriber is a resident of a continuing care facility certified under chapter 651 or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the subscriber's primary care physician must refer the subscriber to that facility's skilled nursing unit or assisted living facility if requested by the subscriber and agreed to by the facility; if the primary care physician finds that such care is medically necessary; if the facility agrees to be reimbursed at the health maintenance organization's contract rate negotiated with similar providers for the same services and supplies; and if the facility meets all guidelines established by the health maintenance organization related to quality of care, utilization, referral authorization, risk assumption, use of the health maintenance organization's network, and other criteria applicable to providers under contract for the same services and supplies. If a health maintenance organization enrolls a new subscriber who already resides in a continuing care facility or a retirement facility as described in this subsection, the health maintenance organization must provide in writing a disclosure of the subscriber's rights under this subsection. If a subscriber's request to be referred to the skilled nursing unit or assisted living facility that is part of the subscriber's place of residence is not honored, the subscriber may use the grievance process provided in s. 641.511.

Florida Statutes 641.511 – Grievance Process for Return to Home Law

641.511 Subscriber grievance reporting and resolution requirements.—
(1) Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, and may submit the grievance for review to the Subscriber Assistance Program panel as provided in s. 408.7056 after receiving a final disposition of the grievance through the organization's grievance process. An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.
(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.
(3) Each organization's grievance procedure, as required under subsection (1), must include, at a minimum:
(a) An explanation of how to pursue redress of a grievance.
(b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization's grievance procedure. The list must include the address and the toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the Subscriber Assistance Program and its toll-free telephone number.
(c) The description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the agency to inform it of the unresolved grievance.
(d) A procedure for establishing methods for classifying grievances as urgent and for establishing time limits for an expedited review within which such grievances must be resolved.
(e) A notice that a subscriber may voluntarily pursue binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization's grievance procedure and as an alternative to the Subscriber Assistance Program. Such notice shall include an explanation that the subscriber may incur some costs if the subscriber

pursues binding arbitration, depending upon the terms of the subscriber's contract.

(f) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of a final decision in writing.

(g) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.

(4)(a) With respect to a grievance concerning an adverse determination, an organization shall make available to the subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the organization's transmittal of the final determination notice of an adverse determination. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.

(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.

(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.

(d) In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.

(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the

organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes. The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, is adopted and incorporated by reference as applicable to all organizations that administer small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1. The claims procedures of the regulations of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, shall be the minimum standards for grievance processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. s. 2560.503-1.

(6)(a) An organization shall establish written procedures for the expedited review of an urgent grievance. A request for an expedited review may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. Unless it is submitted in writing, for purposes of the grievance reporting requirements in subsection (1), the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. For purposes of this subsection, “subscriber” includes the legal representative of a subscriber.

(b) Expedited reviews shall be evaluated by an appropriate clinical peer or peers. The clinical peer or peers shall not have been involved in the initial adverse determination.

(c) In an expedited review, all necessary information, including the organization’s decision, shall be transmitted between the organization and the subscriber, or the provider acting on behalf of the subscriber, by telephone, facsimile, or the most expeditious method available.

(d) In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on behalf of the subscriber, as expeditiously as the subscriber’s medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the subscriber until the subscriber has been notified of the determination.

(e) An organization shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision, if the initial notification was not in writing.
(f) An organization shall provide reasonable access, not to exceed 24 hours after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.
(g) In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.
(h) An organization shall not provide an expedited retrospective review of an adverse determination.
(7) Each organization shall send to the agency a copy of its quarterly grievance reports submitted to the office pursuant to s. 408.7056(12).
(8) The agency shall investigate all reports of unresolved quality of care grievances received from:
(a) Annual and quarterly grievance reports submitted by the organization to the office.
(b) Review requests of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance procedure of the organization.
(9)(a) The agency shall advise subscribers with grievances to follow their organization's formal grievance process for resolution prior to review by the Subscriber Assistance Program. The subscriber may, however, submit a copy of the grievance to the agency at any time during the process.
(b) Requiring completion of the organization's grievance process before the Subscriber Assistance Program panel's review does not preclude the agency from investigating any complaint or grievance before the organization makes its final determination.
(10) Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the Subscriber Assistance Program, as provided in s. 408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must

include the addresses and toll-free telephone numbers of the agency and the Subscriber Assistance Program.

(11) Each organization, as part of its contract with any provider, must require the provider to post a consumer assistance notice prominently displayed in the reception area of the provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, the Subscriber Assistance Program, and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt rules to implement this section.

(12) The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.